

IDAHO BUREAU OF RURAL HEALTH & PRIMARY CARE

Rural Physician Incentive Program (RPIP) Application FY17: July 1, 2016 – June 30, 2017



IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Application Deadline:

Applications must be received by post or delivery to the Bureau of Rural Health & Primary Care on or before:

Tuesday, August 30, 2016, 5:00 p.m. Mountain Time.

Applications received after this date and time will not be considered. Emailed or faxed applications will not be accepted or reviewed. Applicants will receive verification of receipt of the application within one week, and notified of application status by October 30, 2016.

Purpose of the Program:

The Rural Physician Incentive Program (RPIP) offers an opportunity for medical education debt repayment for rural physicians who practice primary care medicine in an Idaho federally-designated health professional shortage area (HPSA) that demonstrates a need for assistance in physician recruitment. "Primary care medicine" for the purposes of RPIP means family medicine, general internal medicine and general pediatrics. If there is a demonstrated high level of need in an eligible area as determined by the board, it may also include obstetrics and gynecology, general psychiatry, general surgery and emergency medicine. RPIP awards are limited to a **maximum of \$100,000** payable over a **four year period**. Awarded funds are disbursed at the end of each year following the term of service. Program authorization can be found in Idaho Code 39, Chapter 59 (<http://legislature.idaho.gov/idstat/Title39/T39CH59.htm>).

Eligibility Requirements:

An applicant must be a rural physician providing primary care medicine in an eligible area (see above). A physician may provide patient care services in primary care medicine in more than one eligible area. The physician must spend a minimum of 28 hours per week on average providing primary care medicine services to patients in an eligible area.

The physician must be a doctor of medicine or doctor of osteopathic medicine and have completed an accreditation council of graduate medical education or American osteopathic association residency. The physician must be Idaho medical board certified/board eligible, be eligible for an unrestricted Idaho medical license and be able to meet the medical staffing requirements of the sponsoring organization when applicable. In addition, the physician must accept Medicare and Medicaid patients within the capacity of his or her medical practice.

Physicians who have paid into the RPIP fund as a student (i.e. received a state supported seat) through either the Washington, Wyoming, Alaska, Montana, Idaho (WWAMI) medical education program or the University of Utah School of Medicine (UUSM), authorized in section 33-3723, Idaho Code, will be given a preference over other applicants. Nonetheless, funding is not limited to these applicants.

A physician is **not** entitled to receive an award under this program if he/she is receiving payments for purposes of repaying qualified medical education debt from another state or from a federal debt repayment program.

Application Evaluation and Assessment:

As defined by statute, the Joint Health Care Access and Physician Incentive Grant Review Board meets at least annually to review all applications based on the following criteria (Idaho Code 39-5910):

First priority selection for physicians who were Idaho resident students and were assessed the rural physician incentive fee and paid into the RPIP fund; followed by physicians who were Idaho residents prior to completing medical school out of state and who did not contribute to the fund; followed by physicians from other states who were not Idaho residents.

The board will also consider demonstrated physician shortage in the eligible area to be benefitted; demonstrated physician recruiting difficulties in the eligible area to be benefitted; support of the medical community and community leaders in the eligible area.

Application Instructions:

All application submissions must be typewritten (with the exception of signatures). No handwritten applications will be accepted. This application must be completed by the physician and the community sponsoring organization. A community sponsoring organization is a hospital, medical clinic or other medical organization located in a HPSA and employs/contracts physicians for purposes of providing primary care medical services to patients. The application form must include a supporting letter from the community sponsoring organization that includes documentation of demonstrated physician shortage and physician recruiting difficulties, as well as, support of the medical community and community leaders.

Applicants must also include a copy of their curriculum vitae/resume with their application materials. The physician applicant must submit loan statements for each educational loan being submitted for medical education debt repayment consideration. **Only verifiable medical school loans will qualify toward the \$100,000 maximum repayment.** Applications must be submitted by post or delivery to the following address:

**Bureau of Rural Health & Primary Care
Attn: Ariel Foster
450 W. State Street – 4th Floor
P.O. Box 83720
Boise, ID 83720-0036**

For further information regarding the program and application process, contact the Bureau of Rural Health & Primary Care at 208-334-0669 or ruralhealth@dhw.idaho.gov.

CHECKLIST FOR APPLICATION SUBMISSION

Each applicant must verify the following information in order to be considered for an Idaho RPIP award. Only complete applications will be considered (this checklist is for your use and does not need to be submitted with the application).

- ☐ **Practice Location is in a medically underserved area designated by the U.S. Department of Health and Human Services as a Health Professional Shortage Area (HPSA). See:**
<http://hpsafind.hrsa.gov/>.
- ☐ **Application to include:**
 - ☐ **Section 1** – To be completed by physician applicant
 - ☐ **Section 2** – To be completed by physician applicant (signature required)
 - ☐ **Section 3** – To be completed by community sponsoring organization (signature required)
- ☐ **Attach a copy of each medical debt loan statement included in the application**
- ☐ **Copy of Curriculum Vitae/Resume**
- ☐ **Letter of support from community sponsoring organization**
The community sponsoring organization must include documentation regarding the need for assistance with physician recruitment and retention in the specified community. Please see attached template found on page 8.

IDAHO RURAL PHYSICIAN INCENTIVE PROGRAM

Application Form – Section 1

Must be typed – Handwritten applications will not be accepted.

(To be completed by Physician)

Personal Information

Last Name:	First Name:
<input type="checkbox"/> MD <input type="checkbox"/> DO	
Are you currently Idaho resident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Were you an Idaho resident prior to entering medical school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide dates:	

Home Address

Street:	
City:	ZIP:
Home Phone:	Email address:

School Information

School of medicine attended:
Dates attended:
Did you pay into the RPIP fund as a student (i.e. receive a state-supported seat) through either the Washington, Wyoming, Alaska, Montana, Idaho (WWAMI) program or the University of Utah School of Medicine (UUSM)? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, from which program? <input type="checkbox"/> WWAMI <input type="checkbox"/> UUSM

Residency Information

Residency program practice information (graduate medical education):
Dates:
Specialty:
Institution:
Location:
Work experience after training:

Licensing and Certification Information

Specialty board certification? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
Licensed to practice medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
Currently unrestricted and licensed to practice medicine in Idaho? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:

Practice Information

Type of practice (i.e., community health center, critical access hospital, rural health clinic, private owned practice):	
Name of the practice location (must be located in a HPSA):	
Address of the practice location:	
Street:	
City:	ZIP:
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time	Start date:
If part-time, what percentage of time is dedicated at this practice location?	
Do you accept Medicare and Medicaid patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Physician Commitment

Please describe your reasons for choosing this practice location and your anticipated commitment to the organization and community. (*limit 1,750 characters, approx. ½ page*):

Other Loan Repayment

Have you applied for National Health Service Corps (NHSC) or another federal loan repayment program? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide details including the application date and whether or not the applicant was awarded:
NOTE: The NHSC does not allow its recipients to have any outstanding service obligation for health professional or other service to the Federal government or a State (e.g., a State Loan Repayment Program obligation) or other entity, <u>unless</u> the obligation would be completed prior to receipt of the NHSC Loan Repayment award. See http://nhsc.hrsa.gov/downloads/lrpapplicationguidance.pdf (page # 5, "Am I eligible").

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Application Form – Section 2

(To be completed by Physician)

Qualified medical education debt means a debt with a financial aid program or financial institution incurred to meet the educational costs of attending a medical school. This amount cannot include undergraduate education loans. Consolidated loans can only include the educational costs of attending medical school.

Eligible Medical Debt Loan Information

A current loan statement must be included in the application for each eligible medical education loan listed below. If you have consolidated your loans for medical school, you must attach a copy of the loan documents for all health profession education costs consolidated into the new loan.

Name of lending institution:	Account number:	Current balance:
		\$
		\$
		\$
		\$
		\$
		\$
Total (include all eligible debts):		\$

WARNING: Any person, who knowingly makes a false statement or misrepresentation in this loan repayment transaction, fraudulently obtains repayment for a loan, or commits any other illegal action in connection with this transaction is subject to repaying any amount received from this program. I have read this statement and understand its contents.

Please initial: _____

WARNING: Please initial stating that you have included a copy of your Curriculum Vitae/Resume with this application

Please initial: _____

If the applicant is selected to receive an RPIP award, a current loan statement with loan balances will need to be submitted to the Bureau of Rural Health & Primary Care prior to establishing a contract to receive the RPIP award.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE:

Signature of Physician Applicant

Date

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Application Form – Section 3

(To be completed by Community Sponsoring Organization)

Community Sponsoring Organization Information

Name:	
Type of community sponsoring organization (i.e., community health center, critical access hospital, rural health clinic, private owned practice):	
Street:	
City:	ZIP:
HPSA county score for the site and discipline to be served by the applicant (http://hpsafind.hrsa.gov/):	
Phone:	Fax:
Contact (name and title):	
Email:	

Community Information

Population size of the community:
Name and location of local area hospital:
Does the applicant physician hold privileges at the local hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No
If not, at what hospital does the applicant hold privileges?
Does the community have a history of difficulty recruiting and retaining physicians? <input type="checkbox"/> Yes <input type="checkbox"/> No

Letter of Support

The community sponsoring organization <u>must</u> provide a letter of support that includes a description of any physician workforce challenges and the need for physician recruitment and retention assistance in the community. This letter of support must be included with this application (see attached letter of support template).
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I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE:

Signature

Title/Affiliation

Date

Community Sponsoring Organization Letter of Support Template

Organization Letterhead
Organization Name
Address
City, ID Zip Code

Date

Joint Health Care Access and Physician Incentive Grant Review Board
Bureau of Rural Health & Primary Care
450 W. State St. – 4th Floor
PO Box 83720
Boise, Idaho 83720-0036

To Whom It May Concern:

Please describe community and any needs with regard to the physician applicant (*limit 1,000 characters; approx. ½ page*).

Please explain the need for assistance with physician recruitment and retention in the area to be served by the physician applicant. Please include information regarding (*limit 1,000 characters; approx. ½ page*):

- efforts made to recruit physicians over the past five years
- the number of physicians lost to retirement or relocation over the past five years
- reasons recruitment will continue to be a challenge for your community

Please describe how your organization and community support the physician applicant (*limit 1,000 characters; approx. ½ page*).

Sincerely,

Signature of CEO or equivalent

Name
Title
Phone
Email